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3.1 Introduction

3.1.1 General Policy

This section covers all Medicaid services provided by dentists and denturists as deemed appropriate by IDHW. It addresses the following:

- Dental guidelines
- Denturist guidelines
- Claims billing
- Claims payment
- Prior authorization

See **Section 2** , **General Billing Information** for information on electronic billing.

3.1.2 Client Eligibility

3.1.2.1 CHIP-B

The CHIP B Program is only valid through 6/30/2006.

Dental services are **not** covered for CHIP-B participants. Refer to the **CHIP-B Appendix**, section B.1.5 for service limitations for CHIP-B participants.

3.1.2.2 QMB (Qualified Medicare Beneficiary) Program:

Clients eligible under **only** the Qualified Medicare Beneficiary (QMB) program, with no other active Medicaid eligibility, are not eligible for dental benefits.

3.1.2.3 PW (Pregnant Women) Program:

Women covered under the Pregnant Women (PW) program are covered for limited dental services. See **Section 3.2.12** for a listing of PW codes.

3.1.2.4 Healthy Connections (HC) Program

Healthy Connections (HC) is Idaho Medicaid's care management program.

- Dental care or oral surgery performed **in the dentist's office** does **not** require a Healthy Connections referral.
- Dental care or oral surgery performed in a **hospital** setting (inpatient or outpatient), or in a free-standing **ambulatory surgical center** (ASC) does require a Healthy Connections referral.

  All providers performing services directly related to the procedure, including the hospital or ASC, anesthesiologists, pathologists, radiologists, laboratory, and physician performing the pre-operative exam, must include the HC referral with their claim.

  The provider performing the oral surgery or dental services should check eligibility to see if the client is enrolled in Healthy Connections, secure the HC referral prior to the date of the services, and forward a copy to the other providers.

The patient's HC primary care physician should perform the preoperative exam, if possible. If the HC provider does not have hospital privileges at the facility where the procedure is to be performed, he/she will need to send a referral to a provider with hospital privileges to cover the pre-operative physical exam.

3.1.3 Reimbursement

Medicaid reimburses dentists on a fee-for-service basis at usual and customary fees, up to the Medicaid maximum allowance. If the provider accepts any Medicaid payment for a covered service, the Medicaid payment must be accepted as payment in full and the client cannot be billed for the difference between the billed amount and the Medicaid allowed amount.

Dentists may make arrangements for private payment with families for services that are not covered by Medicaid if the patient or financially responsible party is informed that the services are not covered by Medicaid before they are rendered.

To obtain a copy of the Idaho Medicaid dental reimbursement schedule, write:

Division of Medicaid
Attn: Dental Consultant
P.O. Box 83720
Boise, ID 83720-0036

Or access it via the Internet at:

http://www.healthandwelfare.idaho.gov/_Rainbow/Documents/medical/dental.pdf

3.1.3.1 Non-covered Services

Non-covered services are procedures not recognized by the American Dental Association (ADA) and/or services not listed in this handbook.

3.2 Covered Benefits and Limitations

3.2.1 Overview

This portion of the handbook lists the various dental services covered by Medicaid with specific limitations and exclusions. See the most recent Current Dental Terminology (CDT) handbook published by the American Dental Association for full definitions.

Children's Dental Services (Section 3.2.3 – 3.2.11) Services provided to children age 0-21 (through the month of their 21st birthday).

PW Dental Services (Section 3.2.12) Services provided to clients of the Pregnant Women (PW) Program

Adult Dental Services (Section 3.2.13). Services provided to adults who have completed the month of their twenty-first birthday

3.2.2 Descriptive Codes

3.2.2.1 Designation of Teeth

01-32	Permanent teeth
A-T	Deciduous (primary teeth)

3.2.2.2 Areas of the Oral Cavity

00	whole of the oral cavity
01	maxillary area
02	mandibular area
10	upper right quadrant
20	upper left quadrant
30	lower left quadrant
40	lower right quadrant

For examples, refer to the most current CDT (Current Dental Terminology) manual.

Supernumerary Teeth: services on supernumerary teeth require prior authorization from the Department. Refer to Section 3.4 *Prior Authorization* for more information.

3.2.3 Children's Dental Services

The following examinations are not allowed in combination on the same day:

Dental Code	Description
General Oral Evaluations	
D0120	Periodic oral evaluation. An evaluation performed on a patient of record to determine any changes in the patient's dental and medical health status since a previous comprehensive or periodic evaluation. This includes periodontal screening and may require interpretation of information acquired through additional diagnostic procedures. Report additional diagnostic procedures separately. One periodic examination is allowed every six months. Includes periodontal screening.
D0140	Limited oral evaluation – problem focused. An evaluation or re-evaluation limited to a specific oral health problem or complaint. This may require interpretation of information acquired through additional diagnostic procedures. Report additional diagnostic procedures separately. Definitive procedures may be required on the same date as the evaluation. Typically, patients receiving this type of evaluation present with a specific problem and/or dental emergencies, trauma, acute infections, etc. This code is not to be billed when a client returns on a later date for follow-up treatment subsequent to either a comprehensive or periodic exam.
D0150	Comprehensive oral evaluation – new or established patient. One comprehensive examination is allowed every 12 months. Six months must elapse before a periodic exam can be paid. Documentation must identify the medical need for a comprehensive level of evaluation. A notation of "comprehensive exam or eval" is not sufficient documentation for payment. A thorough evaluation with findings must be recorded. Typically used by a general dentist and/or a specialist when evaluating a patient comprehensively. This applies to new patients; established patients who have had a significant change in health conditions or other unusual circumstances, or established patients who have been absent from active treatment for 3 or more years. It is a thorough evaluation and recording of the extraoral and intraoral hard and soft tissues. It may require interpretation of information acquired through additional diagnostic procedures. Additional diagnostic procedures should be reported separately. This would include the evaluation and recording of the patient's dental and medical history and a general health assessment. It may typically include the evaluation and recording of dental caries, missing or unerupted teeth, restorations, occlusal relationships, periodontal conditions (including periodontal charting), hard and soft tissue anomalies, oral cancer screening, etc.
D0160	Detailed and extensive oral evaluation – problem focused. A detailed and extensive problem focused evaluation entails extensive diagnostic and cognitive modalities based on the findings of a comprehensive oral evaluation. Integration of more extensive diagnostic modalities to develop a treatment plan for a specific problem is required. The condition requiring this type of evaluation should be described and documented. Examples of conditions requiring this type of evaluation may include dentofacial anomalies, complicated perio-prosthetic conditions, complex temporormandibular dysfunction, facial pain of unknown origin, conditions requiring multi-disciplinary consultation, etc. One detailed and extensive oral evaluation is allowed every 12 months.

Dental Code	Description
D0170	Re-evaluation — limited, problem focused. Established client; not post-operative visit. Assessing the status of a previously existing condition. For example: • a traumatic injury where no treatment was rendered but the patient needs follow-up monitoring; • evaluation for undiagnosed continuing pain • soft tissue lesion requiring follow-up evaluation
Radiographs/Diagnostic Images	
D0210	Intraoral — complete series (including bitewings). Complete series x-rays are allowed only once in a **36-month period**. A complete intraoral series consists of 14 periapicals and one series of 4 bitewings.
D0220	Intraoral periapical — first film.
D0230	Intraoral periapical — each additional film.
D0240	Intraoral — occlusal film.
D0270	Bitewing — single film. Total of 4 bitewings allowed every 6 months.
D0272	Bitewings — 2 films. Total of 4 bitewings allowed every 6 months.
D0274	Bitewings — 4 films. Total of 4 bitewings allowed every 6 months.
D0277	Vertical bitewings — Seven (7) to eight (8) films. Allowed every 6 months. Does not constitute a full mouth intraoral radiographic series.
D0330	Panoramic film. Panorex, panelipse or orthopantograph are also allowed under this code. Panoramic-type films are allowed once in a **36-month period**. This time limitation does not apply to preoperative or postoperative surgery cases. Doing both a panoramic film and an intraoral complete series is not allowed. Up to 4 bitewings or periapicals are allowed in addition to a panoramic film.
D0340	Cephalometric film. Allowed once in a 12-month period.
Test And Laboratory Examination	
D0460	Pulp vitality tests. Includes multiple teeth and contralateral comparison(s), as indicated. Allowed once per visit per day.
D0470	Diagnostic casts.
Diagnostic	
D0999	Unspecified diagnostic procedure, by report. Narrative required when prior authorizing. **Prior authorization is required.**

3.2.4 Preventive Procedures D1000 — D1999

Medicaid provides no additional allowance for a cavitron or ultrasonic prophylaxis.

Dental Code	Description
Dental Prophylaxis	
D1110	Prophylaxis — Adult (age 12 and older). A prophylaxis is allowed once every six months. Removal of plaque, calculus and stains from the tooth structures in the permanent and transitional dentition. It is intended to control local irritational factors. If your client needs this procedure more frequently, request Prior Authorization. Dental.

Dental Code	Description
D1120	Prophylaxis — Child/young adult (under age 12). A prophylaxis is allowed once every 6 months. Removal of plaque, calculus and stains from the tooth structures in the permanent and transitional dentition. It is intended to control local irritational factors. If your client needs this procedure more frequently, request Prior Authorization.
Topical Fluoride Treatments **Prescription strength fluoride product designed solely for use in the dental office, delivered to the dentition under the direct supervision of a dental professional. Fluoride must be applied separately from prophylaxis paste. Application does not include fluoride rinses or "swish".**	
D1203	Topical application of fluoride — one treatment (child). Prophylaxis not included. Allowed once every 6 months for clients up to age 21.
D1204	Topical application of fluoride — one treatment (adult). Prophylaxis not included. Allowed once every 6 months for clients age 21 and older.
Other Preventive Services	
D1351	Sealant — per tooth. Mechanically and/or chemically prepared enamel surface. Allowed for clients up to age 21. Limited to once per tooth every 3 years. Tooth designation required. **A sealant is not allowed in addition to an occlusal restoration on the same tooth.**
Space Management Therapy: Space maintainers are allowed to hold space for missing teeth for clients up to age 21. No reimbursement is allowed for removing maintainers, unless by dentist other than providing dentist. Vertical space maintainers are not covered.	
D1510	Space maintainer — fixed — unilateral. Limited up to age 21. Only allowed once per tooth space. Tooth space designation required.
D1515	Space maintainer — fixed — bilateral. Allowed for clients up to age 21. Only allowed once per arch. Arch designation required.
D1520	Space maintainer, removable — unilateral. Allowed once every 2 years. Allowed for clients up to age 21. Arch designation required.
D1525	Space maintainer, removable — bilateral. Allowed once every 2 years. Allowed for clients up to age 21. Arch designation required.
D1550	Re-cementation of space maintainer. Allowed for clients up to age 21. Only allowed once per arch. Arch designation required.

3.2.5 Restorative Procedures D2000 — D2999

All restorations must be documented in the client's record to include: procedure, surface(s), and tooth number (if applicable). This record must be maintained for a period of five (5) years.

When a multi-surface restoration is billed, the surfaces listed on the claim form must equal the number of surfaces billed. Failure to identify all the surfaces billed will result in denial of service.

3.2.5.1 Posterior Restoration

A one-surface posterior restoration is one in which the restoration involves only one of the 5 surface classifications: mesial, distal, occlusal, lingual, or facial, including buccal or labial.

A 2-surface posterior restoration is one in which the restoration extends to 2 of the 5 surface classifications.

A 3-surface posterior restoration is one in which the restoration extends to 3 of the 5 surface classifications.

A 4-or-more surface posterior restoration is one in which the restoration extends to 4 or more of the 5 surface classifications.

3.2.5.2 Anterior Proximal Restoration

A one-surface anterior proximal restoration is one in which neither the lingual nor facial margins of the restoration extends beyond the line angle.

A 2-surface anterior proximal restoration is one in which either the lingual or facial margins of the restoration extends beyond the line angle.

A 3-surface anterior proximal restoration is one in which both the lingual and facial margins of the restorations extend beyond the line angle.

A 4-or-more surface anterior restoration is one in which both the lingual and facial margins extend beyond the line angle and the incisal angle is involved.

3.2.5.3 Amalgams and Resin Restorations

Reimbursement for pit restoration is allowed as a one-surface restoration.

Adhesives (bonding agents), liners, bases, and the adjustment and/or polishing of sealant and restorations are included in the allowance for the major restoration.

Liners and bases are included as part of the restoration. If pins are used, they should be reported separately.

3.2.5.4 Crowns

When submitting for prior authorization, either an x-ray showing the root canal or an x-ray with a justification detailing the reason for the crown is required.

Requests for re-doing crowns must be submitted for prior approval and include x-ray and justification.

3.2.5.5 Local Anesthesia

Local anesthesia is considered to be part of restorative procedures and therefore is not a separately billable service.

Dental Code	Description
Amalgam Restorations	
D2140	Amalgam — one surface, primary or permanent. Tooth designation required.
D2150	Amalgam — 2 surfaces, primary or permanent. Tooth designation required.
D2160	Amalgam — 3 surfaces, primary or permanent. Tooth designation required.
D2161	Amalgam — 4 or more surfaces, primary or permanent. Tooth designation required.

Dental Code	Description
Resin Restorations: Resin-based composite refers to a broad category of materials including but not limited to composites. May include bonded composite, light-cured composite, etc. Tooth preparation, acid-etching, and adhesives (including resin bonding agents), liners and bases, and curing are included as part of the restoration. Report glass ionomers with these codes when used as restorations. If pins are used, report them separately.	
D2330	Resin-based composite — one surface, anterior. Tooth designation required.
D2331	Resin-based composite — 2 surfaces, anterior. Tooth designation required.
D2332	Resin-based composite – 3 surfaces, anterior. Tooth designation required.
D2335	Resin-based composite – 4 or more surfaces or involving incisal angle (anterior). Tooth designation required.
D2390	Resin-based composite crown, anterior. Full resin-based composite coverage of tooth. Tooth designation required.
D2391	Resin-based composite – one surface, posterior. Used to restore a carious lesion into the dentin or a deeply eroded area into the dentin. Not a preventive procedure. Tooth designation required.
D2392	Resin-based composite – 2 surfaces, posterior. Tooth designation required.
D2393	Resin-based composite – 3 surfaces, posterior. Tooth designation required.
D2394	Resin-based composite – 4 or more surfaces, posterior. Tooth designation required.
Crowns (Prior Authorization is required for codes D2710-D2792)	
D2710	Crown – resin-based composite (indirect). Tooth designation required.
D2721	Crown – resin with predominantly base metal. Tooth designation required.
D2750	Crown – porcelain fused to high noble metal. Tooth designation required.
D2751	Crown – porcelain fused to predominantly base metal. Tooth designation required.
D2752	Crown – porcelain fused to noble metal. Tooth designation required.
D2790	Crown – full cast high noble metal. Tooth designation required.
D2791	Crown – full cast predominantly base metal. Tooth designation required.
D2792	Crown – full cast noble metal. Tooth designation required.
Other Restorative Services	
D2920	Re-cement crown. Tooth designation required.
D2930	Prefabricated stainless steel crown – primary tooth. Tooth designation required.
D2931	Prefabricated stainless steel crown – permanent tooth. Tooth designation required.
D2932	Prefabricated resin crown. Tooth designation required.
D2940	Sedative filling. Temporary restoration intended to relieve pain. Not to be used as a base or liner under a restoration. Tooth designation required. Surface is not required.

Dental Code	Description
D2950	Core buildup, including any pins. Refers to building up of anatomical crown when restorative crown will be placed, whether or not pins are used. A material is placed in the tooth preparation for a crown when there is insufficient tooth strength and retention for the crown procedure. This should not be reported when the procedure only involves a filler to eliminate any undercut, box form, or concave irregularity in the preparation. Tooth designation required. Limited to 2 pins per tooth.
D2951	Pin retention – per tooth, in addition to restoration. Tooth designation required. Limited to 2 pins per tooth.
D2954	Prefabricated post and core in addition to crown. This procedure includes the core material. Tooth designation required.
D2955	Post removal (not in conjunction with endodontic therapy). For removal of posts (e.g., fractured posts) and not to be used in conjunction with endodontic retreatment. Tooth designation required.
D2980	Crown repair. Includes removal of crown, if necessary. Tooth designation required.
D2999	Unspecified restorative procedure, by report. Narrative and tooth designation required when prior authorizing. **Prior authorization is required.**

3.2.6 Endodontics D3000 — D3999

Pulpotomies and root canal procedures cannot be paid with the same date of service for the same tooth.

Local anesthesia is considered to be part of endodontic procedures.

Dental Code	Description
Pulp Capping	
D3110	Pulp cap — direct (excluding final restoration). Procedure in which the exposed pulp is covered with a dressing or cement that protects the pulp and promotes healing and repair. Tooth designation required.
Pulpotomy	
D3220	Therapeutic pulpotomy (excluding final restoration) – removal of pulp coronal to the dentinocemental junction and application of medicament. Surgical removal of a portion of the pulp with the aim of maintaining the vitality of the remaining portion by means of an adequate dressing. To be performed on primary or permanent teeth. This is not to be construed as the first stage of root canal therapy. Once per tooth. Tooth designation required
D3221	Pulpal debridement, primary and permanent teeth. For relief of acute pain prior to conventional root canal therapy. This procedure is not to be used when endodontic treatment is completed on the same day. Tooth designation required.
Root Canal Therapy: Pulpectomy is part of root canal therapy. Includes all appointments necessary to complete treatment; also includes intra-operative radiographs. Does not include diagnostic evaluation and necessary radiographs/ diagnostic images. Root canal therapy (includes treatment plan, x-rays, clinical procedures and follow-up care) is for permanent teeth only. Separate charges are allowable for open and drain if the procedure is done on different days.	
D3310	Anterior (excluding final restoration). Tooth designation required.
D3320	Bicuspid (excluding final restoration). Tooth designation required.

Dental Code	Description
D3330	Molar (excluding final restoration). Tooth designation required.
D3346	Retreatment of previous root canal therapy, anterior. Tooth designation required.
D3347	Retreatment of previous root canal therapy, bicuspid. Tooth designation required.
D3348	Retreatment of previous root canal therapy, molar. Tooth designation required.
Apicoectomy/Periradicular Services	
D3410	Apicoectomy/Periradicular surgery-anterior. Surgery on root of anterior tooth. Does not include placement of retrograde filling material. Tooth designation required.
D3421	Apicoectomy/Periradicular surgery-bicuspid (first root). Surgery on one root of a bicuspid. Does not include placement of retrograde filling material. Tooth designation required.
D3425	Apicoectomy/Periradicular surgery-molar (first root). Surgery on one root of a molar tooth. Does not include placement of retrograde filling material. Tooth designation required.
D3426	Apicoectomy/Periradicular surgery (each additional root). For bicuspids and molar surgeries when more than one root is treated during the same procedure. Does not include retrograde filling material placement. Tooth designation required.
D3430	Retrograde filling - per root. For placement of retrograde filling material during periradicular surgery procedures. Tooth designation required.
D3999	Unspecified endodontic procedure, by report. Narrative and tooth designation required. **Prior authorization is required.**

3.2.7 Periodontics D4000 — D4999

Dental Code	Description
Surgical services (including usual postoperative care) — local anesthesia is considered to be part of periodontal procedures.	
D4210	Gingivectomy or gingivoplasty – 4 or more contiguous teeth or bounded teeth spaces per quadrant. Quadrant designation(s) required.
D4211	Gingivectomy or gingivoplasty – one to 3 contiguous teeth or bounded teeth spaces per quadrant. Quadrant designation(s) required.
Non-surgical Periodontal Service	
D4320	Provisional splinting - intracoronal. This is an interim stabilization of mobile teeth.
D4321	Provisional splinting - extracoronal. This is an interim stabilization of mobile teeth.

Dental Code	Description
D4341	Periodontal scaling and root planing – 4 or more contiguous teeth or bounded teeth spaces per quadrant. Allowed once in a 12-month period. This procedure involves instrumentation of the crown and root surfaces of the teeth to remove plaque and calculus from these surfaces. This procedure is indicated for clients with periodontal disease and is therapeutic, not prophylactic, in nature. Root planing is the definitive procedure designed for the removal of cementum and dentin that is rough, and/or permeated by calculus or contaminated with toxins or microorganisms. Some soft tissue removal occurs. This procedure may be used as a definitive treatment in some stages of periodontal disease and/or as a part of pre-surgical procedures in others. Quadrant designation required.
D4342	Periodontal scaling and root planing – 1 to 3 teeth, per quadrant. Allowed once in a 12-month period. Quadrant designation required.
D4355	Full mouth debridement to enable comprehensive periodontal evaluation and diagnosis. The gross removal of plaque and calculus that interferes with the ability of the dentist to perform a comprehensive oral evaluation. This preliminary procedure does not preclude the need for additional procedures. Allowed once in a 12-month period.
Other Periodontal Services	
D4910	Periodontal maintenance. This procedure is instituted following periodontal therapy (surgical and /or non-surgical periodontal therapies exclusive of D4355) and continues for the life of the dentition. It includes removal of the bacterial plaque and calculus from supragingival and subgingival regions, site specific scaling and root planing where indicated, and/or polishing the teeth. If new or recurring periodontal disease appears, additional diagnostic and treatment procedures must be considered. Allowed once in a 3 month period.
D4999	Unspecified periodontal procedure, by report. Narrative is required. This code must be Prior Authorized.

3.2.8 Prosthodontics D5000 — D6999

3.2.8.1 Removable Prosthodontics D5000 — D5899

Complete dentures placed immediately must be of structure and quality to be considered the final prosthesis. Transitional or interim treatment dentures are not covered. No additional reimbursements are allowed for denture insertions. Routine post-delivery care, including complete and partial denture adjustments/relines, are considered part of the initial denture construction service for 6 months after delivery of the dentures. A separate exam fee will be not be allowed during that time for problems related to the dentures.

If partial or complete dentures are inserted during a month when the client is not eligible, but other work, including laboratory work, is completed during an eligible period, the claim for the dentures is allowed. Use the impression date, not the seating date, as the service date.

Limitations on Dentures:

- The Medicaid dental program covers only one partial or complete denture per arch every 5 calendar years.
- Replacement of lost or broken dentures within the 5 year period are not covered.

- Partial dentures for children under the age of 12 require prior authorization.
- When billing "flippers", use the appropriate ADA *interim partial denture* code. Do not bill a partial denture code for flippers. Interim partial dentures require Prior Authorization for children up to age 21. Flippers or interim partial dentures are not covered for adults.

Undelivered Dentures:

Laboratory and professional fees may be paid under procedure code D5899 for an **undelivered** partial or complete denture if the client:

- Decides not to complete the partial or complete denture, or
- Leaves the state, or
- Cannot be located, or
- Expires

Prior authorization is required for D5899. Submit a Request for Prior Authorization, including an invoice listing lab and professional fees, and bill procedure code D5899 on a separate line for each arch.

Providers who have already received payment for dentures but were unable to deliver the dentures must refund the Medicaid payment, and then request prior authorization for D5899. Failure to follow this process with undelivered dentures is considered accepting payment for services not rendered.

Dentures Delivered and Returned by Client:

- Dentures provided by a DENTIST:

  Medicaid's payment for dentures includes routine adjustments up to 6 months from the date dentures were placed. Clients are expected to notify the provider of any problems they are having with the denture(s) and return to the provider for needed adjustments within the 6 month period. If a client returns unsatisfactory dentures within the 6 month adjustment period, the provider should notify Care Management at (208) 364-1839. Clients who do not return unsatisfactory dentures to the dentist within 6 months of placement are not eligible for another denture or set of dentures for 5 years.

- Dentures provided by a DENTURIST:

  When a denturist provides dentures, the 90 day unconditional GUARANTEE OF DENTURIST SERVICES, as outlined in Idaho Administrative Code (IDAPA) 24.16.01.476 and Idaho Code Section 54-3320 GUARANTEE ON SERVICES applies. Notify Care Management at (208) 364-1839 if the client returns denture(s) within 90 days of placement, and refund 75% of Medicaid's payment to Medicaid. Clients who return unsatisfactory dentures to a denturist after the 90 day *Guarantee on Services* period are not eligible for additional dentures for 5 years.

Note: Local anesthesia is considered to be part of removable prosthodontic procedures.

Dental Code	Description
Complete Dentures: This includes 6 months of routine post-delivery care following placement.	
D5110	Complete denture – maxillary.
D5120	Complete denture – mandibular.
D5130	Immediate denture – maxillary.
D5140	Immediate denture – mandibular.
Partial Dentures: This includes 6 months of care following placement. Limited to children age 12 - 21.	
D5211	Maxillary partial denture – resin base. Includes any conventional clasps, rests, and teeth.
D5212	Mandibular partial denture – resin base. Includes any conventional clasps, rests, and teeth.
D5213	Maxillary partial denture – cast metal framework with resin denture bases. Includes any conventional clasps, rests, and teeth.
D5214	Mandibular partial denture – cast metal framework with resin denture bases. Includes any conventional clasps, rests, and teeth.
Adjustments To Complete And Partial Dentures: Adjustments done during the first 6 months following placement are included in complete/partial fee allowance.	
D5410	Adjust complete denture – maxillary.
D5411	Adjust complete denture – mandibular.
D5421	Adjust partial denture – maxillary.
D5422	Adjust partial denture – mandibular.
Repairs To Complete Dentures	
D5510	Repair broken complete denture base. Arch designation required.
D5520	Replace missing or broken teeth – complete denture (each tooth), 6 tooth maximum. Tooth designation required.
Repairs To Partial Dentures	
D5610	Repair resin denture base. Arch designation required.
D5620	Repair cast framework. Arch designation required.
D5630	Repair or replace broken clasp. Arch designation required.
D5640	Replace broken teeth, per tooth. Tooth designation required.
D5650	Add tooth to existing partial denture. Does not involve clasp or abutment tooth. Tooth designation required.
D5660	Add clasp to existing partial denture. Involves clasp or abutment tooth.
D5670	Replace all teeth and acrylic on cast metal framework (maxillary).
D5671	Replace all teeth and acrylic on cast metal framework (mandibular).
Denture Relining: No allowance for relines for the first 6 months following placement of denture and then only once every 2 years. Relines done during the first 6 months following placement are included in complete/partial fee allowance.	
D5730	Reline complete maxillary denture (chairside).
D5731	Reline complete mandibular denture (chairside).
D5740	Reline maxillary partial denture (chairside).
D5741	Reline mandibular partial denture (chairside).

Dental Code	Description
D5750	Reline complete maxillary denture (laboratory).
D5751	Reline complete mandibular denture (laboratory).
D5760	Reline maxillary partial denture (laboratory).
D5761	Reline mandibular partial denture (laboratory).
Other Removable Prosthetic Services	
D5850	Tissue conditioning, maxillary - per denture unit.
D5851	Tissue conditioning, mandibular - per denture unit.
D5899	Unspecified removable prosthodontic procedure, by report. Narrative required when prior authorizing. Use **D5899** to report "Unable to deliver full or partial denture" and include invoice listing lab and professional fees and the arch designation. **Prior authorization is required.**

3.2.8.2 Maxillofacial Prosthetics D5900 — D5999

Dental Code	Description
Maxillo-Facial Prosthetics **Prior authorization is required for codes D5931-D5999**	
D5931	Obturator prosthesis, surgical. Narrative required when prior authorizing.
D5932	Obturator prosthesis, definitive. Narrative required when prior authorizing.
D5933	Obturator prosthesis, modification. Narrative required when prior authorizing.
D5934	Mandibular resection prosthesis with guide flange. Narrative required when prior authorizing.
D5935	Mandibular resection prosthesis without guide flange. Narrative required when prior authorizing.
D5936	Obturator prosthesis, interim. Narrative required when prior authorizing.
D5951	Feeding aid. Narrative required when prior authorizing.
D5952	Speech aid prosthesis, pediatric. Narrative required when prior authorizing.
D5953	Speech aid prosthesis, adult. Narrative required when prior authorizing.
D5954	Palatal augmentation prosthesis. Narrative required when prior authorizing.
D5955	Palatal lift prosthesis, definitive. Narrative required when prior authorizing.
D5958	Palatal lift prosthesis, interim. Narrative required when prior authorizing.
D5959	Palatal life prosthesis, modification. Narrative required when prior authorizing.
D5960	Speech aid prosthesis, modification. Narrative required when prior authorizing.
D5982	Surgical stent. Narrative required when prior authorizing. Surgical stent is generally included in reimbursement for the surgical procedure.
D5988	Surgical splint. Narrative required when prior authorizing.
D5999	Unspecified maxillofacial prosthesis, by report. Narrative is required when prior authorizing.

3.2.8.3 Fixed Prosthodontics D6200 — D6999

Dental Code	Description
Other Fixed Partial Denture Services. Procedure codes D6210 through D6920 are not a Medicaid covered benefit. Local anesthesia is considered to be part of Fixed Prosthodontic procedures.	
D6930	Recement fixed partial denture.
D6980	Fixed partial denture repair.
D6999	Unspecified fixed prosthodontic procedure, by report. Narrative is required when prior authorizing. **Prior authorization is required.**

3.2.9 Oral Surgery D7000 — D7999

Extraction codes include services for local anesthesia, suturing, and routine preoperative and postoperative care.

Dental Code	Description
Simple Extraction	
D7111	Extraction, coronal remnants – deciduous tooth. Removal of soft tissue-retained coronal remnants. Tooth designation required.
D7140	Extraction, erupted tooth or exposed root (elevation and/or forceps removal). Includes routine removal of tooth structure, minor smoothing of socket bone, and closure, as necessary. Tooth designation required.
Surgical Extractions	
D7210	Surgical removal of erupted tooth requiring elevation of mucoperiosteal flap and removal of bone and/or section of tooth. Includes cutting of gingiva and bone, removal of tooth structure, minor smoothing of socket bone and closure. Tooth designation required.
D7220	Removal of impacted tooth – soft tissue. Occlusal surface of tooth covered by soft tissue; requires mucoperiosteal flap elevation. Tooth designation required.
D7230	Removal of impacted tooth – partially bony. Part of crown covered by bone; requires mucoperiosteal flap elevation, bone removal, and may require segmentalization of tooth. Tooth designation required.
D7240	Removal of impacted tooth – completely bony. Most or all of crown covered by bone; requires mucoperiosteal flap elevation, bone removal, and may require segmentalization of tooth. Tooth designation required.
D7241	Removal of impacted tooth – completely bony, with unusual surgical complications. Most or all of crown covered by bone; usually difficult or complicated due to factors such as nerve dissection required, separate closure of maxillary sinus required or aberrant tooth position. Allowed only when pathology is present. Tooth designation required.
D7250	Surgical removal of residual tooth roots (cutting procedure). Includes cutting of gingiva and bone, removal of tooth structure, and closure. Can be completed for the same tooth number as previously extracted without prior approval. Tooth designation required.
Other Surgical Procedures	
D7270	Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth. Includes splinting and/or stabilization. Tooth designation required.
D7280	Surgical access of an unerupted tooth. An incision is made and the tissue is reflected and bone removed as necessary to expose the crown of an impacted tooth not intended to be extracted. Tooth designation required. Limited to clients less than 21 years of age.
D7286	Biopsy of oral tissue – soft. For surgical removal of an architecturally intact specimen only. This code is not to be used at the same time as codes for apicoectomy/periradicular curettage.
D7287	Exfoliative cytological sample collection. For collection of non-transepithelial cytology sample via mild scraping of the oral mucosa.
Alveoloplasty – surgical preparation of ridge for dentures.	
D7320	Alveoloplasty not in conjunction with extractions – per quadrant. No extractions performed in an edentulous area. Quadrant designation is required.

Note: For Oral and Maxillofacial Surgeons, most surgical procedures in the D7911 to D7996 category should be converted to the CPT coding system and submitted on a CMS-1500 claim form. Use your medical provider number on these claims.

Dental Code	Description
Excision Of Bone Tissue	
D7471	Removal of lateral exostosis (maxilla or mandible). Arch designation required.
Surgical Incision	
D7510	Incision and drainage of abscess – intraoral soft tissue. Involves incision through mucosa, including periodontal origins.
Repair Of Traumatic Wounds – Excludes closure of surgical incisions.	
D7910	Suture of recent small wounds up to 5 cm.
Other Repair Procedures	
D7960	Frenulectomy (frenectomy or frenotomy) – separate procedure. The frenum may be excised when the tongue has limited mobility; for large diastemas between teeth; or when the frenum interferes with a prosthetic appliance; or when it is the etiology of periodontal tissue disease.
D7970	Excision of hyperplastic tissue — per arch. Arch designation required.
D7971	Excision of pericoronal gingiva. Surgical removal of inflammatory or hypertrophied tissues surrounding partially erupted/impacted teeth. Arch designation required.
D7999	Unspecified oral surgery procedure, by report. Narrative required when prior authorizing. **Prior Authorization is required.**

3.2.10 Orthodontics D8000 — D8999

Dental Code	Description
Orthodontics: Prior Authorization requests need to be submitted to the Department prior to providing orthodontia. Limited to clients age 0 to 21 years who meet the eligibility requirements, and the Handicapping Malocclusion Index as evaluated by the State Medicaid dental consultant. **Transfers: Clients already in orthodontic treatment who transfer to Idaho Medicaid must have their continuing treatment justified and authorized by the Idaho Medicaid dental consultants.**	
Limited Orthodontics: Orthodontic treatment with a limited objective, not involving the entire dentition. It may be directed at the only existing problem, or at only one aspect of a larger problem in which a decision is made to defer or forego more comprehensive therapy. Monthly adjustments are not a covered benefit for limited orthodontics.	
D8010	Limited orthodontic treatment of the primary dentition. Justification and treatment plan required when prior authorizing.
D8020	Limited orthodontic treatment of the transitional dentition. Justification and treatment plan required when prior authorizing.
D8030	Limited orthodontic treatment of the adolescent dentition. Justification and treatment plan required when prior authorizing.
D8040	Limited orthodontic treatment of the adult dentition. Justification and treatment plan required when prior authorizing.

Dental Code	Description
Comprehensive Orthodontic Treatment: The coordinated diagnosis and treatment leading to the improvement of a client's craniofacial dysfunction and/or dentofacial deformity including anatomical, functional, and aesthetic relationships. Treatment usually, but not necessarily, utilizes fixed orthodontic appliances, and can also include removable appliances, headgear, and maxillary expansion procedures. **Must score at least 8 points on the State's Handicapping Malocclusion Index.**	
D8070	Comprehensive orthodontic treatment of the transitional dentition. Models, panorexes, and treatment plan are required when prior authorizing.
D8080	Comprehensive orthodontic treatment of the adolescent dentition, up to 16 years of age. Models, panorexes, and treatment plan are required when prior authorizing.
D8090	Comprehensive orthodontic treatment of the adult dentition, 16-21 years of age. Justification required. Models, panoramic film, and treatment plan are required when prior authorizing.
Minor Treatment To Control Harmful Habits	
D8210	Removable appliance therapy. Removable indicates client can remove; includes appliances for thumb sucking and tongue thrusting. Justification required when prior authorizing. Will be allowed up to 2 adjustments when prior authorizing. Replacement appliances are not covered.
D8220	Fixed appliance therapy. Fixed indicates client cannot remove appliance; includes appliances for thumb sucking and tongue thrusting. Justification required when prior authorizing. Will be allowed up to 2 adjustments when prior authorizing. Replacement appliances are not covered.
Other Orthodontic Services	
D8670	Periodic orthodontic treatment visit. Adjustments monthly. When utilizing treatment codes D8050 and D8060, a maximum of 10 adjustments will be allowed. When utilizing treatment codes D8070, D8080, or D8090, a maximum of 24 adjustments over 2 years will be allowed (12 per year) when prior authorizing. When utilizing treatment codes D8210 or D8220, 2 adjustments will be allowed per treatment when prior authorizing.
D8680	Orthodontic retention (removal of appliances, construction and placement of retainer(s)). Allowed once per arch per lifetime. Replacement appliances are not covered unless prior authorized. Includes both upper and lower retainer if applicable.
D8691	Repair of orthodontic appliance. Limited to 1 occurrence.
D8999	Unspecified orthodontic procedure, by report. Narrative is required when prior authorizing. No payment for lost or destroyed appliances. **Prior authorization is required.**

3.2.11 Adjunctive General Services D9000 — D9999

Dental Code	Description
Unclassified Treatment	
D9110	Palliative (emergency) treatment of dental pain - minor procedure (open and drain abscess, etc.). This is typically reported on a "per visit" basis for emergency treatment of dental pain. Tooth or quadrant designation required. This code is allowed once per day. Treatment must actually be provided when billing this code. Open and drain is included in the fee for root canal when performed during the same sitting. This code is not allowed with a restoration on the same day.
Anesthesia	
D9220	Deep sedation/general anesthesia — first 30 minutes. Not included as general anesthesia are tranquilization; nitrous oxide; or enteral or parenteral administration of analgesic, sedative, tranquilizing, or dissociative agents. Anesthesia time begins when the doctor administering the anesthetic agent initiates the appropriate anesthesia and non-invasive monitoring protocol and remains in continuous attendance of the patient. Anesthesia services are considered completed when the patient may be safely left under the observation of trained personnel and the doctor may safely leave the room to attend to other patients or duties.
D9221	Deep sedation/general anesthesia — each additional 15 minutes.
D9230	Analgesia, anxiolysis, inhalation of nitrous oxide. Allowed once per day.
D9241	Intravenous conscious sedation/analgesia – first 30 minutes. **Provider certification required.** Anesthesia time begins when the doctor administering the anesthetic agent initiates the appropriate anesthesia and non-invasive monitoring protocol and remains in continuous attendance of the patient. Anesthesia services are considered completed when the patient may be safely left under the observation of trained personnel and the doctor may safely leave the room to attend to other patients or duties.
D9242	Intravenous conscious sedation/analgesia – each additional 15 minutes. **Provider certification required.**
Professional Consultation	
D9310	Consultation (diagnostic service provided by dentist or physician other than practitioner providing treatment). Type of service provided by dentist whose opinion or advice regarding evaluation and/or management of a specific problem may be requested by another dentist or physician. The dentist may initiate diagnostic and/or therapeutic services at the same or subsequent visit. The written or verbal request for a consultation must be documented in the patient's medical record. The consultant's opinion and any services that were ordered or performed must also be documented in the client's medical record and communicated to the requesting dentist or physician.
Professional Visits	
D9410	House/Extended Care facility call. Includes visits to nursing homes, long-term care facilities, hospice sites, institutions, etc. Report in addition to reporting appropriate code numbers for actual services performed. Limited to once per day per client. To be used when client's health restrictions require treatment at the house/extended care facility. If procedures are done in the hospital, use procedure code D9420.

Dental Code	Description
D9420	Hospital calls. May be reported when providing treatment in hospital or ambulatory surgical center, in addition to reporting appropriate code numbers for actual services performed. Limited to once per day per client. Not covered for routine preoperative and postoperative. If procedures are done in other than hospital or surgery center use procedure code D9410.
D9430	Office visit for observation (during regularly scheduled hours). **No other services performed.**
D9440	Office visit -- after regularly scheduled hours.
Miscellaneous Services	
D9920	Behavior management. May be reported in addition to treatment provided when the client is developmentally disabled, mentally ill, or is especially uncooperative and difficult to manage, resulting in the dental staff providing additional time, skill and/or assistance to render treatment. Notation and justification must be written in the client's record identifying the specific behavior problem and the technique used to manage it. Allowed once per client per day. Describe the highest level of behavior management technique used for the client in the comments field of paper or electronic claim.
D9930	Treatment of complications (post-surgical) – unusual circumstances.
D9940	Occlusal guard – removable dental appliances, which are designed to minimize the effects of bruxism (tooth grinding) and other occlusal factors. No payment for replacement of lost or destroyed appliances.
D9951	Occlusal adjustment, limited. May also be known as equilibration; reshaping the occlusal surfaces of teeth to create harmonious contact relationships between the maxillary and mandibular teeth. Presently includes discing/odontoplasty/enamoplasty. Typically reported on a per-visit basis. Allowed once every 12 months.
D9952	Occlusal adjustment, complete. Occlusal adjustment may require several appointments of varying length, and sedation may be necessary to attain adequate relaxation of the musculature. Study casts mounted on an articulating instrument may be used for analysis of occlusal disharmony. It is designed to achieve functional relationships and masticatory efficiency in conjunction with restorative treatment, orthodontics, orthognathic surgery, or jaw trauma, when indicated. Occlusal adjustment enhances the healing potential of tissues affected by the lesions of occlusal trauma. Justification required when prior authorizing. **Prior authorization is required.**
D9999	Unspecified adjunctive procedure, by report. Narrative required when prior authorizing. **Prior authorization is required.**

3.2.12 PW Dental Services

The following are the only codes covered for women on the Pregnant Women (PW) program. For more information on the PW program, see **Section 1, General Provider and Client Information**.

Dental Code	Description
Clinical Oral Examinations	
D0140	Limited oral evaluation – problem focused. An evaluation or re-evaluation limited to a specific oral health problem or complaint. This may require interpretation of information acquired through additional diagnostic procedures. Report additional diagnostic procedures separately. Definitive procedures may be required on the same date as the evaluation. Typically, patients receiving this type of evaluation present with a specific problem and/or dental emergencies, trauma, acute infections, etc. This code is not to be billed when a client returns on a later date for follow-up treatment subsequent to either a comprehensive or periodic exam.
Radiographs	
D0220	Intraoral – periapical, first film.
D0230	Intraoral – periapical, each additional film.
D0330	Panoramic film. Panorex, panelipse or orthopantograph are also allowed under this code. Panoramic-type films are allowed once in a **36-month period**. This time limitation does not apply to preoperative or postoperative surgery cases. Doing both a panoramic film and an intraoral complete series is not allowed. Up to 4 bitewings or periapicals are allowed in addition to a panoramic film.
Restorative Services	
D2940	Sedative filling. Temporary restoration intended to relieve pain. Not to be used as a base or liner under a restoration. Tooth designation required. Surface is not required.
Pulp Capping	
D3220	Therapeutic pulpotomy (excluding final restoration) – removal of pulp coronal to the dentinocemental junction and application of medicament. Surgical removal of a portion of the pulp with the aim of maintaining the vitality of the remaining portion by means of an adequate dressing. To be performed on primary or permanent teeth. This is not to be construed as the first stage of root canal therapy. Once per tooth. Tooth designation required
Adjunctive Periodontal Services	
D4341	Periodontal scaling and root planing – 4 or more teeth per quadrant. Allowed once in a 12-month period. This procedure involves instrumentation of the crown and root surfaces of the teeth to remove plaque and calculus from these surfaces. This procedure is indicated for clients with periodontal disease and is therapeutic, not prophylactic, in nature. Root planing is the definitive procedure designed for the removal of cementum and dentin that is rough, and/or permeated by calculus or contaminated with toxins or microorganisms. Some soft tissue removal occurs. This procedure may be used as a definitive treatment in some stages of periodontal disease and/or as a part of pre-surgical procedures in others. Quadrant designation required.
D4342	Periodontal scaling and root planing – 1 to 3 teeth, per quadrant. Allowed once in a 12-month period. Quadrant designation(s) required.

Dental Code	Description
D4355	Full mouth debridement to enable comprehensive periodontal evaluation and diagnosis. The gross removal of plaque and calculus that interferes with the ability of the dentist to perform a comprehensive oral evaluation. This preliminary procedure does not preclude the need for additional procedures. Allowed once in a 12-month period.
Oral Surgery: Extractions — includes local anesthesia, suturing, and routine preoperative and postoperative care.	
D7111	Extraction, coronal remnants – deciduous tooth. Removal of soft tissue-retained coronal remnants. Tooth designation required.
D7140	Extraction, erupted tooth or exposed toot (elevation and/or forceps removal. Includes routine removal of tooth structure, minor smoothing of socket bone, and closure, as necessary. Tooth designation required.
Surgical: Extractions – includes local anesthesia, suturing, and routine preoperative and postoperative care.	
D7210	Surgical removal of an erupted tooth requiring elevation of the mucoperiosteal flap and removal of bone and/or section of tooth. Includes cutting of gingival and bone, removal of tooth structure, minor smoothing of socket bone and closure. Tooth designation required.
D7220	Removal of impacted tooth – soft tissue. Occlusal surface of tooth covered by soft tissue; requires mucoperiosteal flap elevation. Tooth designation required.
D7230	Removal of impacted tooth – partially bony. Part of crown covered by bone; requires flap elevation, bone removal, and may require segmentalization of tooth. Tooth designation required.
D7250	Surgical removal of residual tooth roots (cutting procedure). Includes cutting of soft tissue and bone, removal of tooth structure, and closure. Can be completed for the same tooth number as previously extracted without prior approval. Tooth designation required.
Surgical Incision	
D7510	Incision and drainage of abscess – intraoral soft tissue. Involves incision through mucosa, including periodontal origins.
Unclassified Treatment	
D9110	Palliative (emergency) treatment of dental pain – minor procedure (open and drain abscess, etc). Open and drain is included in the fee for root canal when performed during the same sitting. This is typically reported on a “per visit” basis for emergency treatment of dental pain. Tooth or quadrant designation required. This code is not to be billed when no minor procedure is provided.
Professional Consultation	
D9310	Consultation (diagnostic service provided by dentist or physician other than practitioner providing treatment). Type of service provided by dentist whose opinion or advice regarding evaluation and/or management of a specific problem may be requested by another dentist or physician. The dentist may initiate diagnostic and/or therapeutic services at the same or subsequent visit. The written or verbal request for a consultation must be documented in the patient’s medical record. The consultant’s opinion and any services that were ordered or performed must also be documented in the client’s medical record and communicated to the requesting dentist or physician.
Professional Visits	

Dental Code	Description
D9420	Hospital call – May be reported when providing treatment in hospital or ambulatory surgical center, in addition to reporting appropriate code numbers for actual services performed. Limited to once per day per client. Not covered for routine preoperative and postoperative.
D9440	Office visit – after regularly scheduled hours.
D9930	Treatment of complications (post-surgical) – unusual circumstances.

3.2.13 Adult Dental Services

A Medicaid client is considered to be an "adult" as of the first day of the first month **after** his/her twenty-first (21) birthday.

For dates of service April 2, 2003 through June 30, 2003, refer to Medicaid Information Release 2003-22

Effective for dates-of-service on or after **July 1, 2003**, services for Medicaid adult clients are currently limited to the tables below.

Codes in the tables below may have abbreviated descriptions: Refer to **Sections 3.2.1** through **3.2.10** for more information on guidelines and limitations.

Dental Code	Description
General Oral Evaluations	
D0120	Periodic oral evaluation. An evaluation performed on a patient of record to determine any changes in the patient's dental and medical health status since a previous comprehensive or periodic evaluation. This includes periodontal screening and may require interpretation of information acquired through additional diagnostic procedures. Report additional diagnostic procedures separately. One periodic examination is allowed every 6 months. Includes periodontal screening.
D0140	Limited oral evaluation – problem focused. An evaluation or re-evaluation limited to a specific oral health problem or complaint. Not to be used when a client returns on a later date for follow-up treatment subsequent to either a comprehensive or periodic exam. This may require interpretation of information acquired through additional diagnostic procedures. Report additional diagnostic procedures separately. Definitive procedures may be required on the same date as the evaluation. Typically, patients receiving this type of evaluation present with a specific problem and/or dental emergencies, trauma, acute infections, etc. This code is not to be billed when a client returns on a later date for follow-up treatment subsequent to either a comprehensive or periodic exam.
D0150	Comprehensive oral evaluation – new or established patient. One comprehensive examination is allowed every 12 months. Six months must elapse before a periodic exam can be paid. Documentation must identify the medical need for a comprehensive level of evaluation. A notation of "comprehensive exam or eval" is not sufficient documentation for payment. A thorough evaluation with findings must be recorded. Typically used by a general dentist and/or a specialist when evaluating a patient comprehensively. This applies to new patients; established patients who have had a significant change in health conditions or other unusual circumstances, or established patients who have been absent from active treatment for 3 or more years. It is a thorough evaluation and recording of the

Dental Code	Description
	extraoral and intraoral hard and soft tissues. It may require interpretation of information acquired through additional diagnostic procedures. Additional diagnostic procedures should be reported separately. This would include the evaluation and recording of the patient's dental and medical history and a general health assessment. It may typically include the evaluation and recording of dental caries, missing or unerupted teeth, restorations, occlusal relationships, periodontal conditions (including periodontal charting), hard and soft tissue anomalies, oral cancer screening, etc.
Radiographs/Diagnostic Images	
D0210	Intraoral – complete series (including bitewings). Complete series x-rays are allowed only once in a **36**-month period. A complete intraoral series consists of 14 periapicals and one series of 4 bitewings.
D0220	Intraoral periapical – first film.
D0230	Intraoral periapical – each additional film.
D0270	Bitewing – single film. Total of 4 bitewings allowed every 6 months.
D0272	Bitewings – 2 films. Total of 4 bitewings allowed every 6 months.
D0274	Bitewings – 4 films. Total of 4 bitewings allowed every 6 months.
D0277	Vertical bitewings – 7 to 8 films. Allowed every 6 months. Does not constitute a full mouth intraoral radiographic series.
D0330	Panoramic film. Panorex, panelipse or orthopantograph are also allowed under this code. Panoramic-type films are allowed once in a **36**-month period. This time limitation does not apply to preoperative or postoperative surgery cases. Doing both a panoramic film and an intraoral complete series is not allowed. Up to 4 bitewings or periapicals are allowed in addition to a panoramic film.
Dental Prophylaxis	
D1110	Prophylaxis – allowed once every 6 months. Removal of plaque, calculus and stains from the tooth structures in the permanent and transitional dentition. It is intended to control local irritational factors. If your client needs this procedure more frequently, request Prior Authorization.
Fluoride Treatments	
D1204	Topical application of fluoride –1 treatment. Prophylaxis not included. Allowed once every 6 months for clients age 21 and older.
Amalgam Restorations	
D2140	Amalgam – 1 surface, primary or permanent. Tooth designation required.
D2150	Amalgam – 2 surfaces, primary or permanent. Tooth designation required.
D2160	Amalgam – 3 surfaces, primary or permanent. Tooth designation required.
D2161	Amalgam – 4 or more surfaces, primary or permanent. Tooth designation required.
Resin Restorations	
D2330	Resin based composite – 1 surface, anterior. Tooth designation required.
D2331	Resin based composite – 2 surfaces, anterior. Tooth designation required.
D2332	Resin based composite – 3 surfaces, anterior. Tooth designation required.
D2335	Resin based composite – 4 or more surfaces or involving incisal angle (anterior. Tooth designation required.
D2390	Resin based composite crown, anterior. Fill resin-based composite coverage of tooth. Tooth designation required.
D2391	Resin based composite – once surface posterior. Used to restore a carious

Dental Code	Description
	lesion into the dentin or a deeply eroded area into the dentin. Not a preventive procedure. Tooth designation required.
D2392	Resin based composite – 2 surfaces, posterior. Tooth designation required.
D2393	Resin based composite – 3 surfaces, posterior. Tooth designation required.
D2394	Resin based composite – 4 or more surfaces, posterior. Tooth designation required.
Other Restorative Services	
D2920	Re-cement crown. Tooth designation required.
D2931	Prefabricated stainless steel crown – permanent tooth. Tooth designation required.
D2940	Sedative filling. Temporary restoration intended to relieve pain. Not to be used as a base or liner under a restoration. Tooth designation is required. Surface is not required.
Pulpotomy	
D3220	Therapeutic pulpotomy (excluding final restoration) - removal of pulp coronal to the dentinocemental junction and application of medicament. Surgical removal of a portion of the pulp with the aim of maintaining the vitality of the remaining portion by means of an adequate dressing. To be performed on primary or permanent teeth. This is not to be construed as the first stage of root canal therapy. Once per tooth. Tooth designation required
D3221	Pulpal debridement, primary and permanent teeth. For relief of acute pain prior to conventional root canal therapy. This procedure is not to be used when endodontic treatment is completed on the same day. Tooth designation required.
Periodontal Services	
D4341	Periodontal scaling and root planing – 4 or more teeth per quadrant. Allowed once in a 12-month period. This procedure involves instrumentation of the crown and root surfaces of the teeth to remove plaque and calculus from these surfaces. This procedure is indicated for clients with periodontal disease and is therapeutic, not prophylactic, in nature. Root planing is the definitive procedure designed for the removal of cementum and dentin that is rough, and/or permeated by calculus or contaminated with toxins or microorganisms. Some soft tissue removal occurs. This procedure may be used as a definitive treatment in some stages of periodontal disease and/or as a part of pre-surgical procedures in others. Quadrant designation required.
D4342	Periodontal scaling and root planing – 1 to 3 teeth, per quadrant. This procedure involves instrumentation of the crown and root surfaces of the teeth to remove plaque and calculus from these surfaces. This procedure is indicated for clients with periodontal disease and is therapeutic, not prophylactic, in nature. Root planing is the definitive procedure designed for the removal of cementum and dentin that is rough, and/or permeated by calculus or contaminated with toxins or microorganisms. Some soft tissue removal occurs. This procedure may be used as a definitive treatment in some stages of periodontal disease and/or as a part of pre-surgical procedures in others. Allowed once in a 12-month period. Quadrant designation required.
D4355	Full mouth debridement to enable comprehensive periodontal evaluation and diagnosis. The gross removal of plaque and calculus that interferes with the ability of the dentist to perform a comprehensive oral evaluation. This preliminary procedure does not preclude the need for additional procedures. Allowed once in a 12-month period.
D4910	Periodontal maintenance. This procedure is instituted following periodontal therapy (surgical and/or non-surgical periodontal therapies exclusive of

Dental Code	Description
	D4355) and continues for the life of the dentition. It includes removal of the bacterial plaque and calculus from supragingival and subgingival regions, site specific scaling and root planing where indicated, and/or polishing the teeth. If new or recurring periodontal disease appears, additional diagnostic and treatment procedures must be considered. Allowed once in a 3 month period. This code should only be used for clients who have completed active (surgical or non-surgical) periodontal therapy.
Removable Prosthodontics- Refer to Section **3.2.7** for guidelines and limitations. Dentures include 6 months of routine post-delivery care following placement.	
D5110	Complete denture – maxillary.
D5120	Complete denture – mandibular.
D5130	Immediate denture – maxillary.
D5140	Immediate denture – mandibular.
D5211	Maxillary partial denture – resin base. Includes any conventional clasps, rests, and teeth.
D5212	Mandibular partial denture – resin base. Includes any conventional clasps, rests, and teeth.
D5410	Adjust complete denture – maxillary
D5411	Adjust complete denture – mandibular.
D5421	Adjust partial denture – maxillary.
D5422	Adjust partial denture – mandibular.
Repairs to Complete Dentures	
D5510	Repair broken complete denture base. Arch designation required
D5520	Replace missing or broken teeth – complete denture (each tooth). tooth designation required.
Repairs to Partial Dentures	
D5610	Repair resin denture base. Arch designation required.
D5620	Repair cast framework. Arch designation required.
D5630	Repair or replace broken clasp. Arch designation required.
D5640	Replace broken teeth, per tooth. Tooth designation required.
D5650	Add tooth to existing partial denture. Does not involve clasp or abutment tooth. Tooth designation required.
D5660	Add clasp to existing partial denture. Involves clasp or abutment tooth.
D5670	Replace all teeth and acrylic on cast metal framework (maxillary)
D5671	Replace all teeth and acrylic on cast metal framework (mandibular)
Denture relining: No allowance for relines for the first 6 months following placement of denture, and then only once every 2 years. Relines done during the first 6 months following placement are included in complete/partial fee allowance.	
D5730	Reline complete maxillary denture (chairside).
D5731	Reline complete mandibular denture (chairside)
D5740	Reline partial maxillary denture (chairside).
D5741	Reline partial mandibular denture (chairside)
D5750	Reline complete maxillary denture (laboratory).
D5751	Reline complete mandibular denture (laboratory).
D5760	Reline partial maxillary denture (laboratory).
D5761	Reline partial mandibular denture (laboratory).
D5899	Unspecified removable prosthodontic procedure, by report. Narrative required when authorizing. Use D5899 to report “Unable to deliver full or partial

Dental Code	Description
	denture" and include invoice listing lab and professional fees and the Arch designation required. Prior authorization is required.
Simple Extraction	
D7111	Extraction, coronal remnants – deciduous tooth. Removal of soft tissue-retained coronal remnants. Tooth designation required.
D7140	Extraction, erupted tooth or exposed root (elevation and/or forceps removal). Includes routine removal of tooth structure, minor smoothing of socket bone, and closure, as necessary. Tooth designation required.
Surgical Extractions	
D7210	Surgical removal of erupted tooth requiring elevation of mucoperiosteal flap and removal of bone and/or section of tooth. Includes cutting of gingival and bone, removal of tooth structure, minor smoothing of socket bone and closure. Tooth designation required.
D7220	Removal of impacted tooth – soft tissue. Occlusal surface of tooth covered by soft tissue; requires mucoperiosteal flap elevation. Tooth designation required.
D7230	Removal of impacted tooth – partially bony. Part of crown covered by bone; requires mucoperiosteal flap elevation, bone removal, and may require segmentalization of tooth. Tooth designation required.
D7240	Removal of impacted tooth – completely bony. Most or all of crown covered by bone; requires mucoperiosteal flap elevation, bone removal, and may require segmentalization of tooth. Tooth designation required.
D7241	Removal of impacted tooth – completely bony, with unusual surgical complications. Most or all of crown covered by bone; usually difficult or complicated due to factors such as nerve dissection required, separate closure of maxillary sinus required or aberrant tooth position. Allowed only when pathology is present. Tooth designation required.
D7250	Surgical removal of residual tooth roots (cutting procedure). Includes cutting of gingiva and bone, removal of tooth structure, and closure. Can be completed for the same tooth number as previously extracted without prior approval. Tooth designation required.
D7286	Biopsy of oral tissue – soft. For surgical removal of an architecturally intact specimen only. This code is not to be used at the same time as codes for apicoectomy/periradicular curettage.
Surgical Incision	
D7510	Incision and drainage of abscess — intraoral soft tissue. Involves incision through mucosa, including periodontal origins.
Repair of Traumatic Wounds – Excludes closure of surgical incisions.	
D7910	Suture of recent small wounds up to 5 cm.
Other Repair Procedures	
D7970	Excision of hyperplastic tissue – per arch. Arch designation required.
D7971	Excision of pericoronal gingival. Surgical removal of inflammatory or hypertrophied tissues surrounding partially erupted/impacted teeth. Arch designation required.
Unclassified Treatment	
D9110	Palliative (emergency) treatment of dental pain – minor procedure (open and drain abscess, etc.). Open and drain is included in the fee for root canal when performed during the same sitting. This is typically reported on a "per visit" basis for emergency treatment of dental pain. Tooth or arch designation required. This code is not to be billed when no minor procedure is provided.
Anesthesia	

Dental Code	Description
D9220	Deep sedation/general anesthesia – first 30 minutes. Not included as general anesthesia are tranquilization; nitrous oxide; or enteral or parenteral administration of analgesic, sedative, tranquilizing, or dissociative agents. Anesthesia time begins when the doctor administering the anesthetic agent initiates the appropriate anesthesia and non-invasive monitoring protocol and remains in continuous attendance of the patient. Anesthesia services are considered completed when the patient may be safely left under the observation of trained personnel and the doctor may safely leave the room to attend to other patients or duties.
D9221	Deep sedation/general anesthesia – each additional 15 minutes.
D9230	Analgesia, anxiolysis, inhalation of nitrous oxide. Allowed once per day.
D9241	Intravenous conscious sedation/analgesia – first 30 minutes. **Provider certification required.** Anesthesia time begins when the doctor administering the anesthetic agent initiates the appropriate anesthesia and non-invasive monitoring protocol and remains in continuous attendance of the patient. Anesthesia services are considered completed when the patient may be safely left under the observation of trained personnel and the doctor may safely leave the room to attend to other patients or duties.
D9242	Intravenous conscious sedation/analgesia – each additional 15 minutes. **Provider certification required.**
Professional Consultation	
D9310	Consultation (diagnostic service provided by dentist or physician other than practitioner providing treatment). Type of service provided by dentist whose opinion or advice regarding evaluation and/or management of a specific problem may be requested by another dentist or physician. The dentist may initiate diagnostic and/or therapeutic services at the same or subsequent visit. The written or verbal request for a consultation must be documented in the patient's medical record. The consultant's opinion and any services that were ordered or performed must also be documented in the client's medical record and communicated to the requesting dentist or physician.
Professional Visit	
D9410	House/extended care facility call. Includes visits to nursing homes, long-term care facilities, hospice sites, institutions, etc. Report in addition to reporting appropriate code numbers for actual services performed. Limited to once per day per client. To be used when client's health restrictions require treatment at the house/extended care facility. If procedures are done in the hospital, use procedure code D9420.
D9420	Hospital call. May be reported when providing treatment in hospital or ambulatory surgical center, in addition to reporting appropriate code numbers for actual services performed. Limited to once per day per client. Not covered for routine preoperative and postoperative care. If the procedure are done in other than hospital or surgery center use procedure code D9410.
D9440	Office visit — after regularly scheduled hours.
Miscellaneous Service	
D9920	Behavior management. May be reported in addition to treatment provided when the client is developmentally disabled, mentally ill, or is especially uncooperative and difficult to manage, resulting in the dental staff providing additional time, skill and/or assistance to render treatment. Notation and justification must be written in the client's record identifying the specific behavior problem and the technique used to manage it. Allowed once per client per day. Describe the highest level of behavior management technique used for the client in the comments field of paper or electronic claim.

Dental Code	Description
D9930	Treatment of complications (post surgical) — unusual circumstances.

3.3 Denturist Policy Guidelines

3.3.1 Overview

Approved services are limited to those services allowed by Idaho code for Idaho licensed denturists. Claims may be submitted electronically or on an approved American Dental Association claim form. See Section 3.5 for more information.

3.3.1.1 Adult Denture Services Restrictions

Refer to **Section 4.2.13 Adult Dental Services** for service limitations for Medicaid adult clients. A Medicaid client is considered an "adult" as of the first month after the month of his/her twenty-first (21) birthday.

3.3.2 Client Eligibility

Clients without eligibility restrictions are eligible for denturist services. Clients eligible for the PW program or who have only QMB eligibility are not eligible for denturist services. Refer to **Sections 1.3** and **3.1.2** for more information on eligibility. Eligibility must be verified with MAVIS (Medicaid Automated Voice Information System) (800) 685-3757 before services are rendered.

3.3.3 Prior Authorization

Laboratory and professional fees may be paid under procedure code D5899 for an undelivered partial or complete denture if the client:

- Decides not to complete the partial or complete denture
- Leaves the state
- Cannot be located
- Expires

Prior authorization is required for D5899. Submit a Request for Prior Authorization, including an invoice listing lab and professional fees, and bill procedure code D5899 on a separate line for each arch.

Providers who have already received payment for dentures but were unable to deliver the dentures must refund the Medicaid payment, and then request prior authorization for D5899. Failure to follow this process with undelivered dentures is considered accepting payment for services not rendered.

3.3.4 Reimbursement

Denturists will be reimbursed for procedures on a fee-for-service basis. If a provider accepts Medicaid payment for a covered service, the Medicaid payment must be accepted as full payment and the client cannot be billed for the difference between the billed amount and the Medicaid allowed amount.

3.3.5 Service Limitations

Denture reline is allowed once every 2 years. Complete and partial denture adjustments/relines are considered part of the initial denture construction service for the first 6 months.

Only 1 upper and one lower partial or full denture is covered in a 5 calendar year period. Complete dentures placed immediately must be of structure and quality to be considered the final prosthesis. Transitional or interim treatment

dentures are not covered. No additional reimbursement is allowed for denture insertions.

If complete dentures are inserted during a month when the client is not eligible, but other work, including laboratory work, is completed during an eligible period, the claim for the dentures is allowed. Use the impression date, not the seating date, as the service date.

Adult clients have restricted benefits. Refer to Section **3.2.13 Adult Dental Services** for more information.

3.3.6 Procedure Codes

The following codes are valid denturist procedure codes:

Dental Code	Description
D5110	Complete denture – maxillary
D5120	Complete denture – mandibular
D5130	Immediate denture – maxillary
D5140	Immediate denture – mandibular
D5410	Adjust complete denture – maxillary
D5411	Adjust complete denture – mandibular
D5421	Adjust partial denture – maxillary
D5422	Adjust partial denture – mandibular
D5510	Repair broken complete denture base. Arch designation required.
D5520	Replace missing or broken teeth – complete denture (each tooth), Six teeth maximum. Tooth designation required.
D5610	Repair resin denture base. Arch designation required.
D5620	Repair cast framework. Arch designation required.
D5630	Repair or replace broken clasp. Arch designation required.
D5640	Replace broken teeth – per tooth. Tooth designation required.
D5650	Add tooth to existing partial denture. Does not involve clasp or abutment tooth. Tooth designation required.
D5660	Add clasp to existing partial denture, not requiring the altering or oral tissue or natural teeth. Tooth designation required.
D5670	Replace all teeth and acrylic on cast metal framework (maxillary)
D5671	Replace all teeth and acrylic on cast metal framework (mandibular)
D5730	Reline complete maxillary denture (chairside)
D5731	Reline complete mandibular denture (chairside)
D5740	Reline partial maxillary denture (chairside)
D5741	Reline partial mandibular denture (chairside)
D5750	Reline complete maxillary denture (laboratory)
D5751	Reline complete mandibular denture (laboratory)
D5760	Reline partial maxillary denture (laboratory)
D5761	Reline partial mandibular denture (laboratory)
D5899	Unable to deliver full denture. Arch designation required. Include invoice listing lab and professional fees and the arch designation. See *Section 3.3.3* and *Section 3.4* for more information. **Prior authorization is required.**

3.4 Prior Authorization

3.4.1 How to Request Dental Prior Authorization

All procedures that require prior authorization must be approved prior to the service being rendered. Prior authorization requires submission of the appropriate dental prior authorization form and diagnostics. Verbal authorizations will not be given. Retroactive authorization will be given only in an emergency situation or as the result of retroactive eligibility.

Prior authorization of Medicaid dental procedures does not guarantee payment. The client's Medicaid eligibility must be verified by the provider before the authorized service is rendered.

Prior authorization forms for general dentistry and orthodontics are included in the Forms Appendix. They can be duplicated as needed. The forms must be filled out completely.

Attach or include any pertinent information to substantiate the request for prior authorization, such as x-rays, models, and narratives when appropriate. A Medicaid dental consultant reviews the requested procedure(s) with documentation and returns the approvals or denials via a "Notice of Decision for Medical Assistance Benefits" letter. If the request for prior authorization is denied, a dental consultant's explanation will be included.

When billing for services that require prior authorization, the prior authorization (PA) number is **required** to be on the claim form. Be sure to inform all associated providers of the PA number.

Approved authorizations are valid for 1 year from the date of Medicaid authorization, unless otherwise indicated on the PA approval letter. Clients must be Medicaid eligible on the date of service or the prior authorization is void.

Send prior authorization requests to:

Division of Medicaid
Attn: Dental Consultant
P.O. Box 83720
Boise, ID 83720-0036

Phone: (208) 364-1839

Note:
Any questions regarding the prior authorization procedure or prior authorization requirements should be addressed to the Medicaid Dental Consultant, at - (208) 364-1839.

See **Section 2.3.2** for more information on electronically billing services that require prior authorizations.

3.4.1.1 Submit In Writing for Prior Authorization Changes

If changes are required on a prior authorization, such as procedure was done outside of the START and STOP dates, or another procedure was provided rather than the procedure that was initially authorized, submit in writing to the address above requesting the change. Include the client's name, Medicaid number, prior authorization number, tooth number(s) if applicable, and what needs to be changed.

3.4.1.2 Prior Authorization Code List

For descriptions and limitations for the codes listed below, please refer to **Section 3.2.3** through **3.2.11 Children Dental Services** and **Section 3.2.13 Adult Dental Services**.

Children's Dental Services

D0999	D3999	D5952	D6999	D8210
D2710	D4999	D5953	D7999	D8220
D2721	D5899	D5954	D8010	D8670
D2750	D5931	D5955	D8020	D8680
D2751	D5932	D5958	D8030	D8691
D2752	D5933	D5959	D8040	D8999
D2790	D5934	D5960	D8070	D9952
D2791	D5935	D5982	D8080	D9999
D2792	D5936	D5988	D8090	
D2999	D5951	D5999		

Adult Dental Services

D5899

3.5 Claim Form Billing

3.5.1 Which Claim Form to Use

Claims that do not require attachments may be billed electronically using PES software (provided by EDS at no cost) or other HIPAA compliant vendor software.

To submit electronic claims, use the HIPAA-compliant 837 transaction.

Idaho Medicaid encourages the use of ADA dental claim form 1999 (2000). Processing of other ADA forms will take longer and cause a delay in reimbursement. Idaho Medicaid does **not** currently accept the 2002-2003 ADA dental claim form.

All claims must be received within 1 year of the date of service.

Oral Surgeons: when billing for extractions, use the correct CDT procedure code and an ADA or electronic dental claim form. Use your Medicaid dental provider number.

3.5.2 Electronic Claims

For PES software billing questions, consult the Idaho PES Handbook. Providers using vendor software or a clearinghouse should consult the user manual that comes with their software.

3.5.2.1 Guidelines for Electronic Claims

Detail Lines
Idaho Medicaid allows up to 50 detail lines for electronic HIPAA 837 Dental claims.

National HCPCS or CDT procedure code
Idaho Medicaid does **not** accept state-only procedure codes.

Modifiers
Although HIPAA allows up to 4 modifiers, Idaho Medicaid does **not** accept modifiers for dental services.

More than 1 prior authorization (PA) number
Idaho Medicaid allows more than 1 prior authorization number on an electronic HIPAA 837 Dental claim. PA numbers are accepted if designated at the detail, header, or both. The PA number must be on the claim. Paper claims have only 1 PA.

National Oral Cavity Designation (quadrant) codes
Idaho Medicaid accepts the National Oral Cavity Designation Codes (quadrant codes) on electronic and paper dental claims. Idaho Medicaid does **not** accept the sextant codes.

Multiple tooth designations per detail
Although HIPAA allows multiple tooth designations per detail, Idaho Medicaid can only accept 1 tooth designation and unit per detail.

See **Section 2** for more information on electronic billing.

Place-of-Service Codes
The following place-of-service codes (POS) are allowed for dental providers. Not all of the POS (except for 11-office) listed are available for every procedure. Please verify with MAVIS prior to rendering services outside of the provider office.

11	Office
21	Inpatient Hospital
22	Outpatient Hospital
23	Emergency Room
24	Ambulatory Surgical Center
31	Skilled Nursing Center
32	Nursing Facility
54	Intermediate Care Facility/Mentally Retarded (ICF/MR)
71	Public Health Clinic

3.5.3 Guidelines for Paper Claim Forms

If you are not billing electronically, the 1999 (2000) ADA claim form is the preferred form. Other ADA claim forms will take longer to process. See **Section 3.5.3.3** for specific instructions on how to complete the 1999 (2000) form.

3.5.3.1 How to Complete the Paper Claim Form

The following will speed processing of paper claims:

- Complete all required areas of the claim form.
- Print legibly using black ink or use a typewriter.
- When using a printer, make sure the form is lined up correctly so it prints evenly.
- Keep claim form clean. Use correction tape to cover errors.
- Enter all dates using the month, day, century, and year (MM/DD/CCYY) format. Note that in field 24A (From and To Dates of Service) there are smaller spaces for entering the century and year. Refer to specific instructions for field 24A.
- A maximum of 8 line items per claim can be accepted. If the number of services performed exceeds 8 lines, prepare a new claim form and complete all the required elements. **Total each claim separately.**
- Be sure to sign the form in the correct field. Claims will be denied that are not signed.
- Only 1 prior authorization number allowed for paper claims.
- Idaho Medicaid does not allow modifiers for dental claims.
- Do not use staples or paperclips for attachments. Stack them behind the claim.
- Do not fold the claim form(s). Mail flat in a large envelope (recommend 9 x 12).

3.5.3.2 Where to Mail the Form

Send completed claim forms to:

EDS
Dental Claims
P.O. Box 23
Boise, ID 83707

3.5.3.3 1999 (2000) ADA Dental Claim Form

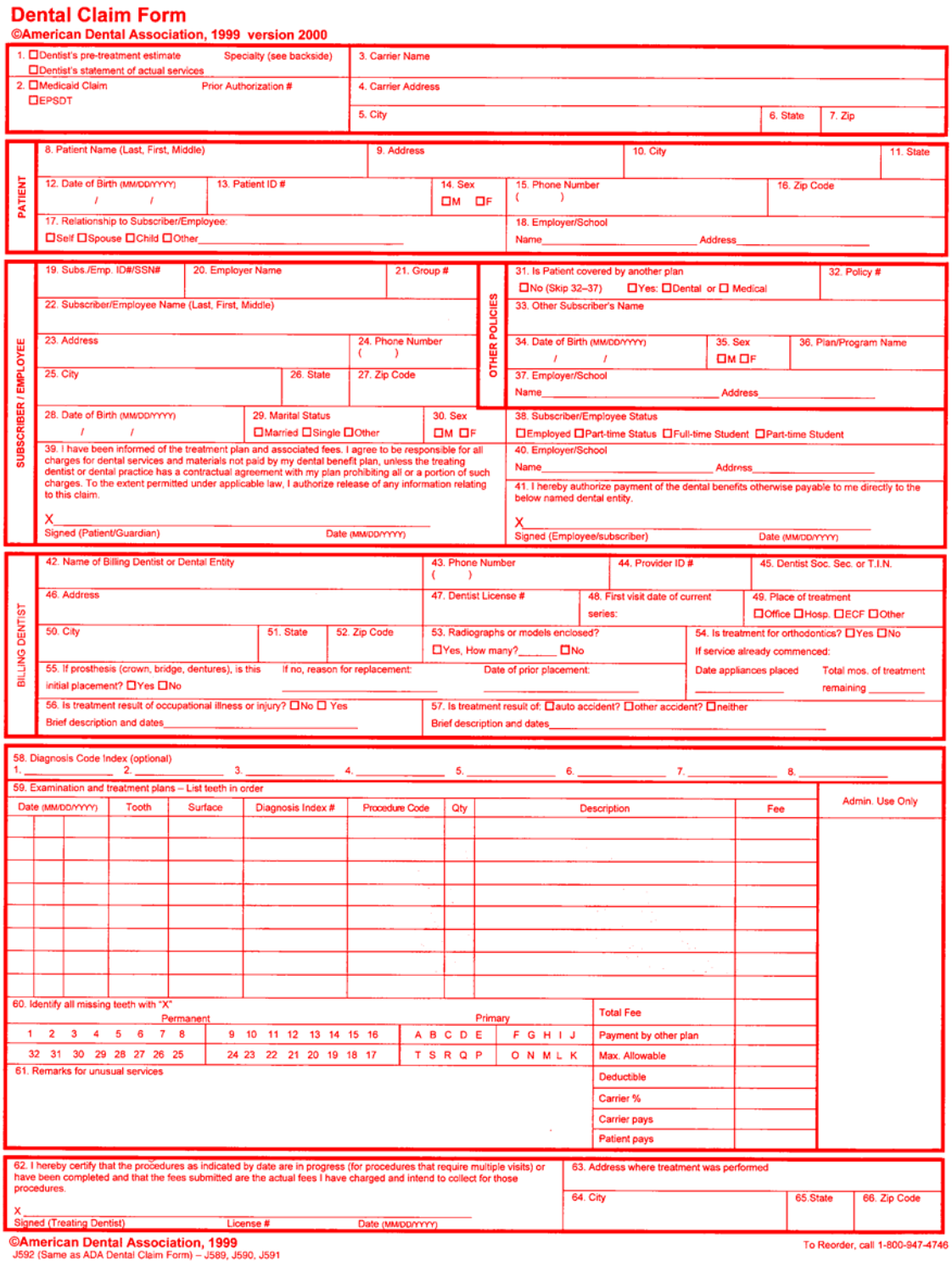
These numbered fields correspond to the ADA 1999 (2000) dental claim form and indicate those fields that **must** be completed for Medicaid submission.

A sample 1999 (2000) claim form with all fields numbered is at the end of this section. Remember that EDS denies incomplete claims, so make every effort to provide valid, complete information as specified on the claim form.

Field	Field Name	Directions
2	Medicaid Claim Prior Authorization #	Check the box marked “Medicaid Claim”. If applicable, enter the PA number (prior authorization number.)
8	Patient Name (Last, First, Middle)	Enter the client’s name exactly as it appears on the client’s eligibility verification response. Enter last name, first name, middle initial, in that order.
13	Patient ID #	Enter the client’s seven-digit Medicaid ID (MID) number exactly as it appears on the client’s plastic Medicaid ID card.
42	Name of Billing Dentist or Dental Entity	Enter your name exactly as it appears on the Provider Master File at EDS.
44	Provider ID #	Enter your complete nine-digit Idaho Medicaid provider number.
49	Place of treatment	Mark an X in the appropriate box. You must complete this field. Mark ‘hospital’ if applicable.
56	Is treatment result of occupational illness or injury?	Mark an X in the appropriate box. If yes, enter a brief description and dates.
57	Is treatment result of: auto accident? Other accident? Neither?	Mark an X in the appropriate box. If yes, enter a brief description and dates.
59	Date	Enter the date the service was provided, using the following format: MMDDCCYY (month, day, century, and year). **Example:** November 24, 2004 becomes 11/24/2004.
59	Tooth	Complete this item using the tooth number or letter codes listed in **Section 3.2.12, Tooth Number Codes**. Also place the arch designation codes in this field.

Field	Field Name	Directions
59	Surface	
59	Procedure Code	Enter the appropriate State dental code from the Idaho Medicaid Dental Program Guidelines handbook.
59	Qty	Enter the quantity or number of units of the service provided. Enter the number of x-rays in this field.
59	Description	Provide a narrative description specifying services provided.
59	Fee	Enter your usual and customary fee for each service provided.
59	For Administrative Use Only	Use this field to enter the performing provider number, if applicable. **This field is used for the Medicaid performing provider number when a group provider number is used in field 44. The performing provider's number must be indicated on each detail line.**
60	Total Fee	Add the charges for all lines; enter the total amount in this field.
60	Payment by other plan	Enter any amount paid by other liable parties or health insurance payments. Attach documentation from an insurance company showing payment or denial to the claim. Do not enter contractual adjustments.
62	Signature (Treating Dentist) License # *(not required)* Date	The provider or his agent must sign and date all claims. If the provider does not wish to sign or signature stamp each individual claim form, a Statement of Certification must be on file at EDS before the claim can be processed. See **Section 1.2** for more information.

3.5.3.4 Sample ADA Dental Claim Form 1999 (2000)



Dental Claim Form

©American Dental Association, 1999 version 2000

1. ☐Dentist's pre-treatment estimate ☐Dentist's statement of actual services — Specialty (see backside)
2. ☐Medicaid Claim ☐EPSDT — Prior Authorization #
3. Carrier Name
4. Carrier Address
5. City | 6. State | 7. Zip

PATIENT

8. Patient Name (Last, First, Middle) | 9. Address | 10. City | 11. State
12. Date of Birth (MM/DD/YYYY) / / | 13. Patient ID # | 14. Sex ☐M ☐F | 15. Phone Number ( ) | 16. Zip Code
17. Relationship to Subscriber/Employee: ☐Self ☐Spouse ☐Child ☐Other
18. Employer/School Name Address

SUBSCRIBER / EMPLOYEE

19. Subs./Emp. ID#/SSN# | 20. Employer Name | 21. Group #
22. Subscriber/Employee Name (Last, First, Middle)
23. Address | 24. Phone Number ( )
25. City | 26. State | 27. Zip Code
28. Date of Birth (MM/DD/YYYY) / / | 29. Marital Status ☐Married ☐Single ☐Other | 30. Sex ☐M ☐F
39. I have been informed of the treatment plan and associated fees. I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted under applicable law, I authorize release of any information relating to this claim.
X Signed (Patient/Guardian) Date (MM/DD/YYYY)

OTHER POLICIES

31. Is Patient covered by another plan ☐No (Skip 32–37) ☐Yes: ☐Dental or ☐ Medical | 32. Policy #
33. Other Subscriber's Name
34. Date of Birth (MM/DD/YYYY) / / | 35. Sex ☐M ☐F | 36. Plan/Program Name
37. Employer/School Name Address
38. Subscriber/Employee Status ☐Employed ☐Part-time Status ☐Full-time Student ☐Part-time Student
40. Employer/School Name Address
41. I hereby authorize payment of the dental benefits otherwise payable to me directly to the below named dental entity.
X Signed (Employee/subscriber) Date (MM/DD/YYYY)

BILLING DENTIST

42. Name of Billing Dentist or Dental Entity | 43. Phone Number ( ) | 44. Provider ID # | 45. Dentist Soc. Sec. or T.I.N.
46. Address | 47. Dentist License # | 48. First visit date of current series: | 49. Place of treatment ☐Office ☐Hosp. ☐ECF ☐Other
50. City | 51. State | 52. Zip Code | 53. Radiographs or models enclosed? ☐Yes, How many?_____ ☐No | 54. Is treatment for orthodontics? ☐Yes ☐No If service already commenced: Date appliances placed Total mos. of treatment remaining
55. If prosthesis (crown, bridge, dentures), is this initial placement? ☐Yes ☐No — If no, reason for replacement: — Date of prior placement:
56. Is treatment result of occupational illness or injury? ☐No ☐ Yes Brief description and dates
57. Is treatment result of: ☐auto accident? ☐other accident? ☐neither Brief description and dates

58. Diagnosis Code Index (optional) 1. 2. 3. 4. 5. 6. 7. 8.

59. Examination and treatment plans – List teeth in order

Date (MM/DD/YYYY)	Tooth	Surface	Diagnosis Index #	Procedure Code	Qty	Description	Fee

Admin. Use Only

60. Identify all missing teeth with "X"

Permanent: 1 2 3 4 5 6 7 8 | 9 10 11 12 13 14 15 16 | 32 31 30 29 28 27 26 25 | 24 23 22 21 20 19 18 17

Primary: A B C D E | F G H I J | T S R Q P | O N M L K

61. Remarks for unusual services

Total Fee	
Payment by other plan	
Max. Allowable	
Deductible	
Carrier %	
Carrier pays	
Patient pays	

62. I hereby certify that the procedures as indicated by date are in progress (for procedures that require multiple visits) or have been completed and that the fees submitted are the actual fees I have charged and intend to collect for those procedures.
X Signed (Treating Dentist) License # Date (MM/DD/YYYY)

63. Address where treatment was performed
64. City | 65. State | 66. Zip Code

©American Dental Association, 1999
J592 (Same as ADA Dental Claim Form) – J589, J590, J591

To Reorder, call 1-800-947-4746